No. 85-1763

Supreme Court, U.S.
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IN THE

Supreme Court of the United States

October Term, 1985

FLORENCE NIGHTINGALE NURSING HOME,

Petitioner,

against

CESAR PERALES, individually and as Commissioner of the New York State Department of Social Services, and GEORGE GROSS, individually and as Administrator/ Commissioner of the New York City Human Resources Administration,

Respondents.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Second Circuit

MEMORANDUM IN OPPOSITION FOR RESPONDENT PERALES

ROBERT ABRAMS
Attorney General of the
State of New York
Attorney for Respondent Perales
Two World Trade Center
New York, New York 10047
(212) 488-4842

O. PETER SHERWOOD
Solicitor General

JUDITH A. GORDON
Assistant Attorney General and Counsel of Record
of Counsel

EDITOR'S NOTE

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Petitioner is a skilled nursing home in New York City that serves private and Medicaid long-term care patients. It seeks plenary consideration of an opinion and judgment of the United States Court of Appeals for the Second Circuit which holds, correctly, that the nursing home, not

government, bears the loss when the home is unable to collect money Medicaid patients owe it from their own funds. *Florence Nightingale Nursing Home* v. *Perales*, 782 F.2d 26 (2d Cir. 1986) (App. A-1[1]).

The Second Circuit opinion recognizes that to the extent a Medicaid patient is required to pay for his care from his own funds, i.e. from "patient income" under federal regulations[2] or "net available [monthly] income" ("NAMI") under state regulation,[3] he is paying for services for which he is not Medicaid-eligible and for which his provider cannot be Medicaid-reimbursed. App. A-4 (citing, *inter alia*, former 42 U.S.C. § 1396a[a][13][E], in force when petitioner's damage claims accrued). *Accord* 42 U.S.C. § 1396a (a)(17) (state plan standards must determine both patient "eligibility for and the extent of medical assistance"); New York Social Services Law § 365-a ("medical assistance" defined as "payment of part or all of the cost of care").

The opinion finds, in consequence, that the federal regulations, 42 CFR §§ 435.725 (categorical Medicaid eligibility) and 435.832 (Medicaid-only eligibility), which specifically prohibit institutional providers from receiving reimbursement for money payable from long-term care patient income, or NAMI, implement federal statutory require-

1. References preceded by "App." are to pages of the appendices to the petition.

2. 42 CFR §§ 435.725, 435.726, 435.733, 435.735, 435.832, 436.832.

3. 18 New York Codes, Rules and Regulations ("NYCRR") § 360.5.

ments. App. A-4-A-5.[4] *Accord* 42 CFR § 435.1002(b) (federal financial participation not available, *inter alia,* for costs payable by long-term care Medicaid patients); 18 New York Codes, Rules and Regulations ("NYCRR") § 360.5 (e) (conforming state regulation); *Friedman* v. *Berger,* 547 F.2d 724 (2d Cir. 1976), *cert. denied,* 430 U.S. 984 (1977) (§ 360.5 [e] setoff on Medicaid reimbursement, up to $28.50, now $40, monthly personal needs allowance, held consistent with federal program requirements).[5]

Petitioner offers three arguments against the Second Circuit opinion and judgment upholding 42 CFR §§ 435.725, 435.832 and the conforming state policy under 18 NYCRR § 360.5(e).[6] None of the arguments presents a special or important reason within Supreme Court Rule 17(1) for

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4. Sections 435.725 and 435.832 both state at paragraph (a): "The [state] agency must reduce its payment to an institution, for services provided to an individual [Medicaid patient] . . ., by the amount that remains after deducting the amounts specified in paragraph (c) . . . from the individual's income." Paragraph (c) allows deductions for the personal needs of long-term care patients, for spousal support and for family support. *Id.* at (1)-(3). Only the personal needs deduction applies to all long-term care patients.

5. The amount of income, or NAMI, a Medicaid patient must pay for his care varies with his available income and resources and with his care status. But, long-term care patients always pay more than outpatients with equivalent income and resources. The reason is self-evident. Providers charge long-term care patients for maintenance needs, e.g. shelter, food, whereas they do not charge outpatients for these needs. Thus, lon-term care patients do not receive a deduction for maintenance needs whereas outpatients do. *Compare* 42 CFR §§ 435.725(c), 435. 733(c), 435.832(c), 436.832(c), 18 NYCRR 360.5(e) (no deduction for individual maintenance needs for long-term care patients) *with* 42 CFR §§ 435.726(c)(1), 435.735 (c)(1), 18 NYCRR § 360.5(b),(c) (deduction for individual maintenance needs for outpatients).

6. Petitioner adopts an unusual argumentative approach. It claims inconsistency between the state policy requiring NAMI setoffs

(footnote continued on next page)

granting a writ of certiorari. And, all three involve manifest error.

Petitioner argues first, and principally, that 42 CFR §§ 435.725, 435.832 and the conforming state policy offend the terms of the "governing" Medicaid statute. Petition at 7, 11. It identifies one state plan subsection, 42 U.S.C. 1396a(a)(13)(E), Pub. L. 92-603, § 249 (1972), amended and renumbered § 1396a(a)(13)(A), Pub. L. 96-499, § 862

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on Medicaid reimbursement and the terms or intent of the federal Medicaid statutes without addressing the controlling federal regulations, 42 CFR §§ 435.725, 435.832. See Petition at 12, 14 (identifying §§ 435.725, 435.832 only indirectly, perhaps with other regulations as the "regulations" adopted by the United States Department of Health and Human Services). See also Brief in Support of the Petition for *Amici Curiae* New York State Health Facilities Association, Inc., Connecticut Association of Health Care Facilities, Inc. and American Health Care Association ("amici curiae brief") (mentioning only the "regulations" in the text [at 10, 11], but identifying §§ 435.725, 435.832, in footnotes [at 3, 11]).

We follow a more traditional approach and consider the state policy, i.e. 18 NYCRR § 360.5(3), in relation to the federal Medicaid statutes and in relation to the specific federal regulations that "command" the state policy. *James* v. *Harris*, 499 F. Supp. 594, 598 (M.D. Ala. 1980), *aff'd on opinion below*, 650 F.2d 814 (5th Cir. 1981) (citing 42 CFR § 435.725, identical to § 435.832 in all material respects; see p. 3 n.4).

Our approach informs the Court that the question presented subsumes challenges to 42 CFR §§ 435.725, 435.832 although the petition does not set out the regulations. See Supreme Court Rule 21 (1)(f). Contrast petition at 2 (regulations omitted). It also informs the Court that if certiorari were granted, the Court would have to remand the cause to join the Secretary of the United States Department of Health and Human Services before it could enter an appropriate order in petitioner's favor. See App. A-2 (state respondent's claim that the Secretary was a necessary party not reached because of finding in his favor). For example, if petitioner prevailed without the remand, the state would have to eliminate NAMI setoffs on Medicaid reimbursement but would not receive commensurate federal financial participation ("FFP") because the federal regulations which command the setoffs, i.e. 42 CFR §§ 435.725 and 435.832, would remain intact. See also 42 CFR § 435.1002(b) (FFP not available for costs payable from patient income, or NAMI).

(a) (1980).[7] It then claims, incorrectly, that the phrase in the 1980 text of § 1396a(a)(13)(A), "payment . . . of . . . services provided under the plan through . . . rates . . . reasonable and adequate to meet the costs which must be incurred . . . to provide care and services in conformity with applicable . . . Federal laws, [and] regulations," means that nursing homes must be "fully reimbursed" for all the costs of all the services they provide to Medicaid patients, including the costs of the services payable from patient income, or NAMI. Petition at 10-11.

Petitioner's reading of § 1396a(a)(13(A) involves several errors. One, § 1396a(a)(13)(A) does not reimburse all

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7. The 1980 text of 42 U.S.C. § 1396(a)(13)(A) states in part: "A State plan for medical assistance must—(13) provide—(A) for payment . . . of . . . skilled nursing facility, and intermediate care facility services provided under the plan through the use of rates (determined in accordance with methods and standards developed by the State . . .) which the State finds, and makes assurances satisfactory to the Secretary, are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with applicable State and Federal laws, regulations, and quality and safety standards . . . ."

The 1972 text of § 1396a(a)(13)(E) stated in part: "A state plan for medical assistance must—(13) provide—(E) . . . for payment of the skilled nursing facility and intermediate care facility services provided under the plan on a reasonable cost basis, as determined in accordance with methods and standards which shall be developed by the State on the basis of cost finding methods approved and verified by the Secretary . . . ."

The city and state respondents claimed below that the substitution of the 1972 phase, "payment . . . on a reasonable cost basis . . ., as determined in accordance with methods and standards . . . developed by the State . . . on the basis of cost finding methods approved . . . by the Secretary," by the 1980 phrase, "payment . . . through the use of rates (determined in accordance with methods and standards developed by the State . . .) which the State finds, and makes assurances satisfactory to the Secretary, are reasonable and adequate to meet the costs . . . incurred by efficiently and economically operated facilities," did not materially amend the subsection. The petitioner now agrees. Petition at 10.

nursing home services provided to Medicaid patients. By its terms, the subsection only reimburses "services provided under the [state] plan" which, in turn, is defined by other federal laws, including the other forty-five subsections in § 1396a(a). Nor does § 1396a(a)(13(A) pay all the costs of the covered state plan services it reimburses. By its terms, the subsection only pays "reasonable," "adequate" cost-based "rates."[8]

Two, petitioner ignores § 1396a(a)(17), the state plan subsection that places services payable from patient income, or NAMI, outside the state plan, thereby eliminating them from reimbursement under § 1396a(a)(13)(A). Subsection 1396a(a)(17) empowers the Secretary of the United States Department of Health and Human Services to prescribe income and resource limits on patient "eligibility for [Medicaid] and the extent of . . . [Medicaid] assistance." Under the subsection's authority, the Secretary has prescribed these limits for long-term care patients in 42 CFR §§ 435.725, 435.832, denying them "eligibility" and "assistance" to the extent of their income, or NAMI. See 42

8. New York has used cost-based rates to reimburse state plan services at least since 1968. *Sigety* v. *Ingraham*, 29 N.Y.2d 110, 112-13 (1971). The period includes the time between 1972 and 1980 when former § 1396a(a)(13)(E) was in force. Thus, to the extent petitioner suggests that the respondents' claim that § 1396a(a)(13)(A) did not materially amend § 1396a(a)(13)(E) means that all the costs of state plan services were reimbursed under § 1396a(a)(13)(E) and are now reimbursable under § 1396a(a)(13)(A), it is incorrect under the terms of § 1396a(a)(13)(E) ("methods and standards" "approved by the Secretary" necessary to determine the "reasonable cost basis" for reimbursement) and their application by the responsible single state agency in New York. See p. 5 n.7; petition at 10.

CFR § 435.3 citing § 1396a[a][17] as statutory authority for §§ 435.725, 435.832).[9]

Thus, when a nursing home provides a Medicaid patient with services payable from patient income, or NAMI, it provides services for which the patient is not Medicaid-eligible and for which Medicaid reimbursement, or "assistance," cannot be paid. Contrast petition at 11 (claiming " 'services provided under the [state] plan' " include services for which a Medicaid patient is not eligible); amici curiae brief at 10-11 (claiming Medicaid eligibility and Medicaid reimbursement are independent and unrelated). Or, as the Second Circuit opinion said, in summary: "NAMI represents the amount that a patient is required to contribute to his or her care. This contribution [for non-Medicaid costs] reduces the amount that the patient is eligible to have paid on his or her behalf . . . ." App. A-4. Contrast petition at 11 (claiming that the Second Circuit found that the costs of services payable from patient income, or NAMI, were not " 'costs' " when the court, in fact, found [at App. A-4] that they were not "costs . . . covered by Medicaid."[10]

9. The amici curiae brief (at 3 n.*, 10-11) accepts 42 CFR §§ 435.725, 435.832 and the conforming state regulation, 18 NYCRR § 360.5(e), as authorized by § 1396a(a)(17). As noted (p. 3 n.6), the petition does not address §§ 435.725, 435.832 and § 360.5(e) directly. However, it appears to concede that they are authorized when it acknowledges that Medicaid patients are "obliged by law" to pay a portion of the costs of state plan services. Petition at 11.

10. The amici curiae brief (at 8-9) claims that the Second Circuit analysis, tracked here, incorporates "fundamental error" (*id.* at 8) because it confuses rates and costs. The error lies with the amici curiae who completely misapprehend the relationship between rates, setoffs for patient income, or NAMI, and reimbursement for state plan services in New York.

New York initially includes the costs of services payable from patient income, or NAMI, in calculating the cost-based rates § 1396a

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Three, if the Court considers petitioner's contention that unless § 1396(a)(13)(A) is read to reimburse all costs of all services nursing homes provide to Medicaid patients, the homes will be obliged to decline Medicaid admissions and reduce quality of care (petition at 7, 8-9; see amici curiae brief at 5, 6-7, 11-12), the New York Court of Appeals provided the appropriate response fifteen years ago in *Sigety* v. *Ingraham*, 29 N.Y.2d 110 (1971). In rejecting the argument advanced by petitioner, there the plaintiff-respondent, that it was entitled to reimbursement in excess of the current rate because its costs exceeded the rate, the court said that projected adverse effects did not provide a basis for declaring the rate and underlying state regulation invalid. *Id.* at 114, 115-16. The court also said that if petitioner, a proprietary nursing home, could not realize a profit at the current reimbursement rate, it could either deliver its services more efficiently or leave the Medicaid program. *Id.* at 115. Petitioner has not yet elected the second option.

Petitioner next argues that Congress did not intend nursing homes to bear the costs of services payable from patient income, or NAMI, if the patient's payment is uncollectible and, for that reason, becomes a nursing home bad debt. Petition at 7, 10, 11-14; see amici curiae brief at 5, 10, 12, 13. Petitioner relies, alternatively, on Congressional intent allegedly expressed in the Medicaid

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(a)(13)(A) requires. Contrast amici curiae brief at 9 (stating that NAMI costs are never treated as " 'costs' " and never enter into the rate calculation process). The state then aggregates the patient income, or NAMI, payable by Medicaid patients in a given nursing home, sets it off against the home's rate, and pays the balance. The state, thereby, reimburses the home under § 1396a(a)(13)(A) only for services provided under the state plan. See pp. 5-8. Contrast amici curiae brief at 9 (stating that it is wrong to deduct NAMI from the nursing home rates).

statutes (Petition at 7, 10, 11-12, 14) and in the Medicare statutes. *Id.* at 13-14.

The Second Circuit opinion observes that uncollectible patient income, or NAMI, could, arguably, be reimbursed as an overhead cost under the Medicaid statutes, but it concludes that the Secretary's view, expressed in 42 CFR §§ 435.725, 435.832, prohibiting reimbursement, is more reasonable and entitled to particular deference. App. A-5. *Accord Connecticut Department of Income Maintenance* v. *Heckler*, 105 S. Ct. 2210, 2215 (1985); *DeJesus* v. *Perales*, 770 F.2d 316, 327 (2d Cir. 1985).

The opinion's conclusion is incontestable for several reasons. One, Congress made its intent manifest in 42 U.S.C. §§ 1396a(a)(13)(A), 1396a(a)(17), and it denied Medicaid reimbursement of uncollectible patient income, or NAMI. See pp. 5-8.

Two, given the promulgation of 42 CFR §§ 435.725, 435.832 in their current form in 1978 (43 FR 45204 [Sept. 29, 1978]), Congress knew the Secretary's view when it amended § 1396a(a)(13)(E) in 1980 and did nothing to modify or overide it. *Lorillard v. Pons*, 434 U.S. 574, 580-81 (1978). Contrast petition at 14 & n.5 (claiming that the Secretary did not prohibit Medicaid reimbursement of uncollectible patient income, or NAMI, until 1982 but acknowledging pre-existing regulations).

Three, the prohibitions against Medicaid reimbursement of uncollectible patient income, or NAMI, in 42 CFR §§ 435.725, 435.832 recognize, correctly, that a Medicaid patient owes his share of the costs of his care, i.e. the costs of

services for which he is not Medicaid-eligible, to his nursing home provider, not to governmental third-party payors. And, they recognize, again correctly, that transactions between Medicaid patient debtors and provider creditors with respect to these costs are matters in which the government has no legal interest.

In contrast to petitioner's claim (petition at 7, 10, 12; see amici curiae brief at 5, 10, 12, 13), the patient debtor-provider creditor relationship does not expand to include the government, much less impose on it the role of guarantor, if the patient or the provider defaults in his obligations. *See James* v. *Harris*, 499 F. Supp. 594, 598 (M.D. Ala. 1980), *aff'd on opinion below*, 650 F.2d 814 (5th Cir. 1981) (recognizing a Medicaid patient's obligation to pay his share of the costs of his care and acknowledging that 42 CFR § 435.725, like § 435.832, "commands" commensurate setoffs from Medicaid reimbursement).

Petitioner, relying alternatively on the Medicare statutes, claims that Congress intends Medicare to reimburse bad debts, akin to uncollectible patient income, or NAMI, and to permit reimbursement of the same bad debts under Medicaid. Petition at 11-13. The argument fails for three reasons.

One, 42 CFR § 405.420, the regulation petitioner cites as specific authority for Medicare's reimbursement of bad debts like uncollectible patient income, or NAMI, only authorizes reimbursement for bad debts related to "covered services." *Id.* at (a)(1). Under Medicaid, patient income, or NAMI, relates to 'uncovered,' i.e. non-state plan, services

See pp. 5-8.

Two, § 405.420(a)(1) only authorizes Medicare reimbursement for bad debts derived from "deductible and coinsurance amounts." Medicaid excludes patient income, or NAMI, from deductible and co-insurance amounts. 42 CFR § 447.53

Three, even if petitioner's comparison between Medicaid and Medicare was not flawed, it shows only that Congress intended states to have the option of reimbursing bad debts that result from uncollectible patient income, or NAMI. New York has declined the option, as evidenced by 18 NYCRR § 360.5(e), and, as petitioner concedes, it had the right to do so.

Last, petitioner argues that the Second Circuit opinion conflicts, in principle, with the Tenth Circuit opinion in *Seneca Nursing Home* v. *Secretary of Social and Rehabilitation Services*, 604 F.2d 1309 (10th Cir. 1979). Petition at 15; see amici curiae at 12-13. There is no conflict.

As both the Second Circuit and petitioner observe, *Seneca* holds (604 F.2d at 1314-15) that a Kansas statute obligates the state to reimburse nursing home providers when they are unable to collect a Medicaid patient's share of the costs of his care from the patient. App. A-5-A-6; petition at 15. The holding does not consider Kansas' obligations under the federal Medicaid program. It, therefore, does not address the prohibitions against Medicaid reimbursement of patient income, or NAMI, in 42 CFR §§ 435.725, 435.832 that are controlling here or the consequent denial of federal financial participation, under 42 CFR § 435.1002(b), to states that violate the prohibitions.

As the Second Circuit also observes, New York does not have a statute analogous to the Kansas statute. App. A-6. Thus, Kansas can reimburse uncollectible patient income, or NAMI, from its general assistance funds while New York cannot. New York Const. art. 17, §1 (aid, care and support of the needy shall be provided by the state as the legislature determines); *id.* at § 3 (legislature shall determine the manner and means of promoting and protecting the health of the state's inhabitants). And, in consequence, the result the Tenth Circuit reached in *Seneca* is not inconsistent with the result the Second Circuit reached in this case.

Therefore, the petition for a writ of certiorari should be denied.

Dated: New York, New York
July 25, 1986

Respectfully Submitted,

ROBERT ABRAMS
Attorney General of the
State of New York
Attorney for Respondent
Perales
Two World Trade Center
New York, New York 10047
(212) 488-4842

O. PETER SHERWOOD
Solicitor General

JUDITH A. GORDON
Assistant Attorney General and Counsel
of Record
of Counsel